Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pine Creek Medical Center

Respondent Name
Texas Builders Insurance Co

MFDR Tracking Number
M4-15-2174-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
March 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was re-created on 5/21/14 and was submitted on 5/28/14 as bill type 141 on the UB-04 in Box 4."

Amount in Dispute: $31.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please note the charges In question were pre-op laboratory tests conducted for a preauthorized outpatient procedure schedule to be performed on 04/03/14 and would be inclusive to the APC reimbursement for CPT code 20680. (See attached EOB as evidence of outpatient surgical encounter."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2014	36415, 80048, 85025	$31.44	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - RN – Not paid under OPPS; services included in APC rate
   - B15 – Procedure/Service is not paid separately
   - P14 – Payment is included in another rsvc/procdre occurring on same day

Issues

1. Did the requestor support why separate payment should be made?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §133.20(g) states in pertinent part, "Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier." Review of the submitted documentation finds;
    a. Original medical claim with "Bill Type 131" received by the carrier and processed on April 18, 2014
    b. Medical claim with creation date, May 21, 2014, with "Bill Type 141"

    The Division finds the Carrier did not return the bill to the health care provider. Therefore, per Rule 133.20 the requirement for a "new bill" was not met. The document created May 21, 2014, will not be considered as part of this review.
2. 28 Texas Administrative Code §134.403 (f) states in pertinent part, "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register." Review of the submitted medical claim finds;
    - Procedure code 36415 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
    - Procedure code 80048 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
    - Procedure code 85025 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

    Based on OPPS rules, no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 16, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.